DRAFT

PLANNING AND IMPLEMENTING PCC+ METRICS

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PLANNING AND IMPLEMENTING PCC+ METRICS

This document contains the following topics:

- what are metrics
- the value of identifying business and clinical metrics before and after using PCC+
- examples of business and clinical metrics
- how to run reports to collect data for metrics

INTRO TO METRICS* FOR PCC+
(*Metrics – A Standard Of Measurement)

PCC+ is a tool to provide:

- Improved delivery of healthcare to AI/AN populations.
- A health summary reminder of previous visits, health maintenance reminders, and test results incorporated into the encounter form.
- An encounter form to document the chief complaint, examination, findings, ordered tests (lab and x-ray), immunizations, procedures, supplies, patient education, medical problems, surgical history, and medications.
- A written process to document patient instructions and orders.
- A form to document the most applicable CPT and ICD9 codes pertaining to the clinic visit.
- A written process to document patient instructions and orders.
- The most current insurance information.

PCC+ is a tool that can gather information from point of contact through and including the billing process to provide a complete, accurate and detailed information resource for the clinic's visit. ***Baseline refers to a measurement or observation data used as a basis for comparison or a control.***

In order to measure the impact of PCC+, the site and clinic need to identify and compare the before and after data and statistics.

The value and importance of these metrics are:

- To determine if PCC+ reduced the outstanding backlogs in the business process

  Example -Days to data entry
  -Days to bill

- To assess whether PCC+ improved revenue

  Example -Increase revenue from previously undocumented or unbilled Supplies
  -Increase revenue from previously "lost" encounter forms or superbills

- To determine if provider and staff have complied with documentation and coding requirements and whether this compliance has led to improved coding and increased reimbursement
- To determine if PCC+ and process flow changes have been instrumental in improving the overall workflow with the clinic and with outside departments
- To demonstrate to management through reports the value and benefit of implementing PCC+

- To measure the return on investment (ROI) for the cost of the project compared to improved revenue

Prior to PCC+ implementation, the site and clinic need to identify and document their "baseline" data. After PCC+ has been implemented and is operational, the sites will need to measure and compare the changes to the baseline data. Usually sites will measure the beneficial outcomes of PCC + at one month, three month, six month, and one year intervals and will continue to monitor in the future at pre-selected timeframes.

Each site may select and monitor any number of these metrics. Usually a clinic will select the metrics that are the most relevant to their site. To prevent "data overload", it is recommended that not all of the metrics referenced below be selected initially. Other metrics can be added at any time after implementation.

The following list provides an overview of the various indicators that can be measured. The indicators not only relate to the business process (documentation, coding and billing) but also address the clinical and quality assurance requirements. Each of the metrics includes how to establish a baseline, a recommended goal, how to measure after PCC+ implementation, and helpful hints. In addition, a description is provided on how to obtain specific data from various areas of the RPMS system that can be used in developing baseline data.

As stated, the selection of the various metrics and indicators is entirely the decision of each clinic. ***However***, the identification and selection of the metrics need to be agreed upon prior to PCC+ implementation and need to be documented as a baseline to measure against. Once the baseline is established and PCC+ is installed and operational, it is recommended that clinics compare the metric data to the selected indicators and metrics at pre-established, pre-determined intervals.

EXAMPLES OF BUSINESS/ADMIN INDICATORS

The following list will provide a description of the various indicators and the "how-to" steps of establishing a baseline and future metric comparison.

Data Entry Backlog

It is very important that data entry of CPT and ICD9 coding not only be accurate but also be entered in a timely manner. With data entry being done on a daily basis, the billing process as well as the insurer reimbursement will be expedited. Stated in the reverse, data entry delays result in excessive backlogs as well as delays in billing and reimbursement.

Baseline -The date which data entry staff is currently working on.
Example – If today's date is 7/15 and they are entering claims from 7/1, their backlog is 14 days.

-Average volume of claims processed per day

The instructions to obtain this report are attached.

Goal -No more than one day behind; Monitor daily.

Measurement

-After PCC+ implementation, monitor and log, either daily or weekly, the date being worked on by data entry. Backlogs of more than one day need to be addressed and resolved immediately. If immediate resolution cannot be accomplished, the project

manager needs to assess the cause of the problem, quickly resolve the issue impacting data entry delays, and obtain support from the staff to decrease the data entry backlog to acceptable levels. If staffing is the issue, it is recommended that another individual be crossed trained in data entry to assist with the day-to-day function and/or backlog.

Helpful Hints

-Data entry needs to validate the provider coding (CPT and ICD9).

-Discrepancies, questions, or missed coding needs to be discussed with the provider immediately.

-Backlogs need to be made current ***before*** PCC+ is implemented.

Coding Accuracy

It is very important in the front-end process to assure accurate CPT and ICD9 coding is provided to the billing department. Coding discrepancies or inaccurate coding can result in denied claims, audits, and/or extensive research and additional provider documentation to substantiate the claim.

Baseline

-Medical Records and data entry validate each other's accuracy from the superbill/encounter form and medical record's notes.

-The business office provides feedback on coding.

-The baseline becomes a percentage of the total number reviewed compared to inaccuracies.

Example – 85% of the total claims reviewed were correctly coded.

Goal

-95% coding accuracy

-Review process monthly (This provides continual training updates to existing and new staff)

Measurement

-Medical Records and data entry validate each other's accuracy from the documentation and provider coding on the PCC+ form along with the medical records notes.

-Billing office does a random sampling of charts to re-validate coding and shares insurer rejection reasons regarding coding or coding incompatibility with data entry.

-The measurement is a comparison of the new percentage of coding accuracy to the baseline.

Helpful Hints

-Existing CPT and ICD9 coding need to be reviewed and updated.

-PCC+ forms need to include the most commonly used updated coding.

-In-service on CPT and ICD9 coding should be provided in a continuous manner to provders and data entry staff.

-If questions occur on correct coding, missed coding but documentation, coding but no documentation, or discrepancy between PCC+ encounter form and medical record's

notes, data entry staff need to immediately discuss and resolve these issues with the provider prior to data entry.

-The proposed process change is that data entry staff will validate provider coding to make sure coding and documentation agree and will subsequently enter the final coding into RPMS. Billing staff will be responsible for filing claims electronically after the data entry staff have entered the coding, posting payments, and following up on rejections.

Form Completion by Provider

In order to assure that accurate information is conveyed to the insurer, to substantiate the level and type of care provided, and to comply with GPRA and JCAHO standards, it is very important that the provider completely document the encounter form. Therefore, providers need to completely document the patient visit as well as provide legible documentation for review by data entry, medical records and potential audits.

Baseline

-Number of forms returned by business office to provider that are incomplete. These need to be tallied by reason, i.e., no signature, missing ICD9 or CPT code, abnormal test results, missed documentation of supplies, etc.

-Number of forms reviewed by Medical Records by month that are incomplete.

-The baseline is either statistics provided by the business office on returns or a survey counting the number of forms returned to the provider by month.

Goal 100% completed accurately

-Provider will update encounter form immediately.

Measurement

-Develop standardized review criteria (number of items to review on each form) of PCC+ encounter form to assure completion.

> Example: Signature, purpose of visit, chief complaint, treatment plan, orders, record documentation, date of onset, CPT/ICD9 coding, abnormal test results or vital signs, etc.

-Have Medical Records scan each PCC+ form for completeness.

-Log the number of incomplete forms. The difference between the total number reviewed and the number of incomplete forms is the percentage completed correctly.

Helpful Hints

-If information is incomplete, return the encounter form to the provider at next-day rounds or directly that day to complete the missing information. Encounter forms need to be corrected during rounds or by the end of that business day.

-Consider having a designated individual review all encounter forms for completeness at the point of care to enable immediate provider feedback and resolution.

Zero Dependent Entry Count Error List

The importance of this indicator is mainly decreasing the errors in data entry as well as saving time researching the information to correct the error.

Zero Dependent Entry Count Error is described as follows:

A value is assigned to each piece of information on the PCC form. If information is missing or services on the same day, same patient is fragmented (such as orphan lab or pharmacy or separate services that have not been grouped), a report will be generated on the errors.

Example: -Provider's name is missing

-Multiple provider/services are not identified or merged

-Purpose of visit is not identified

Baseline

-Number of errors on the report for a given week or month

-Average time to find chart, pull chart, research services in chart, review superbill, resolve one or multiple errors, talk to provider, have provider document and re-enter information into system.

Example: Before PCC+, the average time to correct the error report would be between 2-3 minutes to 30 minutes per chart or on average for all errors, 15 minutes.

Goal Determined by each clinic site

Measurement

-Measure the number of errors before compared to the number of errors after PCC+, either weekly or monthly.

-Measure the average time to research and correct before PCC+ compared to the average time with only using the PCC+ encounter form as the reference document versus the medical record, either weekly or monthly.

-The differences represent the decrease in errors and the decrease in manhours (time).

Decreased Billing Backlog

The reason for monitoring the billing backlog is to assure that bills are sent to the insurer in a timely manner, that claims are not rejected for timely filing limitations, and to assist the clinic in receiving timely reimbursement.

With the billing office staff pulling charts to code clinic superbills or encounter forms, a billing backlog occurs from the following areas: 1) obtaining medical records in a timely manner, 2) reviewing dated information, 3) reviewing incomplete superbills, and 4) applying an applicable code without many times appropriate documentation. Due to the timeframe of review, providers may have forgotten what was ordered or rendered.

Baseline

-Validate baseline date – the current date of service the billing office is working on today.

-Obtain backlog billing report from third party RPMS package. The steps to obtain this report are attached.

Goal -Same day data entry

Measurement

-After PCC+ is implemented and operational, assess billing backlog by date working on compared to baseline data.

-Use the same report from third party billing package to compare metrics.

Helpful Hints

-Have data entry and providers trained in coding

-Validate and correct all coding before data entry

-Transfer responsibility of coding from billers to data entry

-Eliminate the need for billing to pull medical records except for random sampling re-validation or research of rejections

-Have billers file claims electronically (not code), post reimbursement, and resolve denials

Increased Revenue

Each charge rendered for Medicare, Medicaid, and private insurance must be offset with revenue from the insurer. Without this revenue, expenses to treat these patients, such as salaries, supplies, ancillary services, etc. would have a negative financial impact on the clinic's future.

The revenue increase can be attributed from:

- Supplies such as surgical trays, strips for blood glucose, ace bandages, etc.
- Missed services that may or may not have been documented nor coded
- Lost encounter forms

In the past, for supplies, clinics may not have known these services could be covered by some of the insurers; therefore, they were not documented.

Baseline

-Obtain a report from the Third Party Billing system that list the revenue by quarter for the following:

Medicare - Total revenue

Medicaid - Total revenue

- Supplies only

Private Insurer - Total revenue

- Supplies only

This report is obtained in the following manner:

- Go into the RPMS menu option VGEN and QMAN and extract:

-Visits for Medicaid patients

-Patients who were prescribed billable drugs or OTCs.

- Go into search template comparison utility to generate a template of patients who existed in both of the above cohorts.
- Import this data into Excel and calculate the dollar amount billed based on the prices that Medicaid will pay for each drug or OTC.

-Obtain revenue numbers from the business office for a given quarter for the same list referenced above. The process to obtain this report is attached.

Goal Projected goal to be established by each clinic.

Measurement

-Re-run the same report for total revenue as referenced above or obtain revenue numbers from business office and compare revenue changes to baseline.

-Compare revenue data from a given quarter to the baseline data.

-Assess where new or increased revenue was generated from and what contributed to the revenue increase.

Helpful Hints

-Obtain from business office a list of billable drugs and supplies by insurer.

-Note that the Third Party Billing package does not break things out into amount billed or collected for a specific drug. It will just list the total amount for pharmacy.

-If the clinic is using Point-of-Sale package, separate reports can be generated from that system directly.

-Incorporate drugs and supply list onto the PCC+ encounter form

-Educate providers and data entry on documenting the OTC and supplies for the insurers that will reimburse these services

Number of Lost/Incomplete Superbills

With a superbill or encounter form, a claim cannot be submitted to the insurer. Without a claim being submitted, the clinic cannot receive reimbursement for services rendered.

Baseline

-Conduct a survey for several weeks on the number of medical records pulled in which the clinic visit was not billed. This will become your baseline data point.

Goal -100% compliance that all encounter form services are billed.

Measurement

-With the implementation of PCC+, conduct a survey at monthly then quarterly intervals to determine the number of medical records pulled in which the clinic visit was not billed. Compare this number to the baseline.

CLINICAL INDICATORS

The clinical or quality indicators are more specific to complying with internal and national clinical quality guidelines and standards, such as GPRA and JCAHO. Several of the indicators apply specifically to certain clinics. Data related to compliance may or may not have been collected previously due to insufficient information or inadequate documentation in the medical record. Therefore, a baseline may not be able to be obtained unless an active survey is completed for several weeks prior to PCC+ implementation.

The following indicators will demonstrate how the use and structure of PCC+ will enable the providers to comply with quality guidelines and standards with the goal of improving clinical outcomes. The goal is 100% compliance. These measurements can either be accomplished through a manual audit of PCC+ encounter forms or through QMAN, VGEN, or PGEN reports. Detailed directions for obtaining these reports will be provided at the end of this section. Each clinical indicator will reference whether the metric is manual or can be obtained from a specific report.

Data Quality – Health Summary

On the PCC+ form, each clinic has the ability to import the patient's ***Health Maintenance Reminders***. Likewise, each clinic can import and view the patient's ***Active List.*** With only limited space on the PCC+ form to display the reminders and active problems, it is very important to update the medical record health summary data to include only valuable, useful information for the provider. As an example, many of the health summaries inappropriately list acute conditions as active problems, such as upper respiratory infections. In addition, duplicate listings of active problems are often seen. Many of these health summaries are not relevant because of the abundance of information is inappropriate information.

As part of the preparatory process for PCC+, a team should be formed to "clean up" the problem list and other pertinent portions in each patient's record. This would include such items as:

- Educating the provider on what should be included or not included in each of these areas to include PCC documentation training, PCC training manuals and videos
- Ensure that such training is recurrent so it can be given to new providers and staff.
- Listing only abnormal results
- Moving the medications to the pharmacy documentation section
- Transferring medical problems to the appropriate active or inactive list
- Deleting irrelevant notes under each area
- Constructing more of a table of contents of problems in the Health Maintenance section that will become a usable reference to the provider during the clinic visit.

Measurement -After health summaries are updated and PCC+ is operational, a random audit of PCC+ forms and the patient's medical record should be reviewed by Medical Records to determine if the correct information is being recorded for inclusion in the Health Maintenance Reminder and Active Problem List.

-If there is noncompliance, the providers need to be re-educated on the record documentation.

-Number of times the problem list is modified (added, deleted, or changed).

Form Usability

The objective of this review and measurement is to determine if the providers are completing all sections of the PCC+ encounter form and if not, why are they not using specific sections of the form.

During the review process, those areas that are not completed or are rarely completed would be noted. Feedback should be given to the appropriate providers in the clinic to address the value of the specific section, why they did not use this area in documentation, whether the issue was not the relevance but time, and whether it should be maintained on the PCC+ form or deleted. If the providers agree to delete a certain section that appears to be irrelevant to their treatment and documentation, the importance of that data to clinical care and required reporting needs, such as GPRA, JCAHO, ORYX, etc. should be reviewed before considering the removal of a section. In addition, the provider may recommend a change to the form for this area that would enhance documentation.

Measurement -Manual review of PCC+ forms

-Factual comments and responses from providers on benefit of specific area of form

Provider Satisfaction

Through the use of a ten-question survey, each clinic can evaluate the positive and negative comments from the providers on their impressions and viewpoints of the PCC+ form. This is an important process in the beginning stages of implementation to address the providers opinions and continued usage of the encounter form.

Questions addressed in the survey are:

- Rate whether the care of patients has improved.
- State the amount of time it takes to complete the PCC+ form compared to the previously used encounter form
- Has patient education improved?
- Has the form increased your attention to updating the health maintenance summary?
- Has the process for ordering/re-ordering of prescriptions improved?
- What parts of the form do you use routinely?
- What parts of the form do you like the most?
- What parts of the form do you like least? And Why.
- What are the most useful features of the PCC+ encounter form?
- What are the least useful features of the PCC+ encounter form?

Measurement

-Provider comments assessed by clinic team

-Discuss specific issues with provider

-Determine whether changes need to be made to encounter form

Foot Check

For every diabetic patient, the GPRA standard is to complete a "foot check" during every clinic visit with the provider. However, providers do not always document the foot check in the medical records and occasionally forget to complete this process. To obtain 100% compliance for this standard, the PCC+ form for the diabetic clinic can include a diagram of two feet for the provider to document any problems during the routine foot examination and/or other appropriate documentation methods.

Measurement -Medical Records reviews a sampling of PCC+ forms from the diabetic clinic to determine provider compliance in documenting routine foot checks during each visit and adequate documentation of codes and manifestations.

Diabetes Mellitus Education

As part of the GPRA quality standards, diabetic patients need to be instructed, educated, reminded, and queried on their compliance during each clinic visit. Although these are part of the DM standards of care, they do not apply specifically to the documentation of DM education. The PCC+ form should provide an area of the documentation of Diabetes Mellitus education for the provider and/or nurse to review with the patient. After PCC+ has been implemented, it would be important to obtain feedback from the provider and nurse regarding the diabetic education section as to whether they provided and documented the education during each visit, are their areas that are irrelevant or not useful, should any part of the section be revised, and if they are not completing the section, determine the reason why.

Measurement

-Medical Record random sample review of the PCC+ forms to assure compliance.

-Rate of education overall.

-DM audits

-QMAN queries. List of DM patients and patient education within a given timeframe

PAP and Mammogram Rate

As part of the GPRA quality standards, women in the appropriate age groups, need to have a yearly PAP and mammogram examinations. PCC+ form provides the date of the last PAP and Mammogram in the Health Maintenance Summary as a reminder to the provider. The objective of this review is to determine whether the Health Maintenance Reminder is being referenced by the provider.

Measurement -Run a monthly report of all females by stipulated age ranges.

-Have Medical Records review the PCC+ form to determine if yearly examinations were completed in timely manner.

-Assess whether this information was referenced in the Health Maintenance Summary

-For those providers who have not complied, educate the providers on referencing the Health Maintenance Reminder for the last date of PAP and Mammogram.

Immunization Rate

With children, certain timeframes are established for immunization injections. To assure that the children are given their immunizations in a timely manner, the due date for their immunizations can be listed in the Health Maintenance Reminder section of the PCC+ form. The objective of this review is to determine whether the Reminder Section is being referenced by the provider and timely immunizations are occurring and are being documented. This is a GPRA standard.

Measurement -Run a monthly report listing all children seen in the pediatric clinic by specified age ranges.

-Have Medical Records review the PCC+ form to determine if the immunizations have been given on time. Compare the date due to the date given. Alternately, automated RPMS queries can be run to determine the children seen that are deficient in selected immunizations.

-Assess whether this information was referenced in the Health Maintenance Summary

-For those providers who have not complied, educate the providers on referencing the Health Maintenance Reminder for the due date.

FUTURE CLINICAL INDICATORS

Additional clinical indicators are:

Decreased Medication Intervention

Changes in the rate of pharmacy interventions can be monitored through the Pharmacy Intervention Menu. These options are available through the pharmacy as follows:

NINT Enter Pharmacy Intervention

EINT Edit Pharmacy Intervention

PINT Print Pharmacy Intervention

DINT Delete Intervention

VINT View

Last Menstrual Period (LMP) and Family Planning

Information on the LMP needs to be obtained and documented by the nurse during each clinic visit. The provider needs to know if the patient is pregnant and certain tests, such as x-ray, cannot be conducted if the patient is pregnant. To comply with this documentation, the Health Maintenance Summary can be utilized as a reminder to ask this information.

Well Child Visits

GPRA standards state that all children should have a minimum of four well child visits before the age of twenty-seven months.

Pneumococcal and Influenza Vaccinations

In order to reduce the incidence of preventable disease, GPRA standards state that adult diabetics and adults over 65 years of age should have vaccinations for pneumococcal and influenza viruses.

HIV/AIDS Needs Assessment

In order to reduce the high risk of HIV/AIDS, GPRA standards state that clinics need to monitor and assess risk for AI/AN populations.

HOW TO OBTAIN REPORTS AND OUTPUT EXAMPLES

Coding Accuracy

To run this baseline report:

- Select Forms/Data Entry Tracking Menu Option
- ICD Operation/Procedure Coding Audit (This report will list visits by posting date with an option of random samples for a selected data entry operator. Purpose of Visit ICD Operation/Procedure Code and Provider Narrative will also be listed.
- Enter beginning Posting date: t-xx
- Enter Data Entry Operator Name: Name
- Want to limit search by Clinic Type: No
- Do you wish to include only a subset of ICD Operation/Procedure Codes: No
- How many randomized visits do you want: (1-100): Number

Example of Coding Accuracy Report

ICD OPERATION/PROCEDURE CODING AUDIT Page Number
Visit POSTING Dates: Date
Data Entry Operator: Name
Clinic: ALL

ICD O/P Provider Narrative

HR#	Visit Date	Code	Narrative
111111	Aug17, **2001@13:30**	18.29	Removal of lump left ear lobe

Number Of PCC Forms Entered Per Day, Week, Or Month

For Data Entry Backlog

This report counts the number of forms processed by specific data entry clerk along with average counts.

To run this baseline report:

- Log into PCC
- Go to PCC Data Entry Module
- Select DEU – Data Entry Utility
- Select SUP – Supervisory Data Entry Options
- Select FTM – Forms/Data Entry Tracking Menu
- Select CNT – Reports on Counts of Forms Processed
- Enter start date
- Enter end date
- Select specific data entry clerk or select all
- Select:
  1) Clinic Type
  2) Service Category
  3) Visit Type
  4) Include All Visits
- Count number of forms process by: INCLUDE ALL VISITS
- Subtotal by Visit Date – yes or no

Example of Data Entry Report

DATE, Page 1

NUMBER OF FORMS KEYED
DATE ENTRY OPERATOR NAME
VISIT POSTING DATES: FROM/TO

POSTING DATE	#FORMS	#DEP ENT	AVG# DEPT ENT
July 29, 2001	201	975	4
July 30, 2001	50	507	10
July 31, 2001	137	647	4
Aug 01, 2001	35	247	7
Etc.			
Totals for Operator	Total	Total	Total
Grand Total for ALL Operators	Total	Total	Total

DATE, Page number

SUMMARY OF FORMS KEYED BY ALL OPERATORS

VISIT POSTING DATES: FROM/TO

Operator, Name	#days,	#of D/E,	%Forms,	Avg# forms/day,	Avg# ent/day,	Avg# ent/form
Name	24	1712	52.1	71.3	557.1	7.8
Name	19	1573	47.9	82.8	579.2	7.0

- Select view – on screen or printer
  -Print each one or summary
  -Report provides breakdown of:
    1) How many forms done for specific period of time
    2) Averages per day, week, or month
    3) Percent of workload
    4) Number of dependent entries by data entry clerk

Billable Backlog

This report will provide a brief listing of claims flagged as billable for specified dates of service by insurer.

- Go to the Reports Menus in Third Party Billing System
- Select BRRP – Brief (single-line Claim Listing)
- Select #2 – Billing Entity
- Select one of the following, based on insurance:
  - 1) Medicare
  - 2) Medicaid
  - 3) Private Insurance

  For this example, select # 3 – Private Insurance
- Select #3 – Date Range
- Enter Starting Visit Date for the Report, example: t-365
- Enter Ending Date for the Report. Example: t
- Select one of the following:
  - 1) Location
  - 2) Billing Entity
  - 3) Date Range
  - 4) Claim Status
  - 5) Provider
  - 6) Eligibility Status
  - 7) Report Type
- Selection sorting of report by either Visit Type (V) or Clinic (C)
- Select Output Device

Example of Billable Backlog Report by Claim and Visit Date

BRIEF LISTING of CLAIMS Flagged as Billable Date Page 1

For (insurance selected) with VISIT DATES from xx to xx

+++++++

Patient HRN Active Insurer Visit number Date Clinic

For Data On Billable Supplies

This report will provide the HCPCS code for drugs and supplies by insurer for specified date ranges. Included in this report will be the procedure description, count and amount billed along with a total count and total amount billed.

- Go to the Third Party Billing System, Listing of Billed Procedures
- Select one of the following:
    1. Medical
    2. Surgical
    3. Radiology
    4. Laboratory
    5. Anesthesia
    6. Dental
    7. Room & Board
    8. Miscellaneous (HCPCS)
    9. Pharmacy
    10. All
- Selected Desired Category: 8 Miscellaneous (HCPCS)
- Selection one of the following:
    1. Location
    2. Billing Entity
    3. Date Range
    4. Approving Official
    5. Provider
    6. Eligibility Status
    7. Diagnosis Range
    8. CPT Range
- Select the Parameter: 2) Billing Entity
- Select one of the following:
    1. Medicare
    2. Medicaid
    3. Private Insurance
- Select Type of Billing Entity to display: Select insurance
- Select one of the following:
    1. Location
    2. Billing Entity
    3. Date Range
    4. Approving Official
    5. Provider
    6. Eligibility Status
    7. Diagnosis Range
    8. CPT Range
- Select one of the parameters: 3) Date Range
- Select one of the following:
    1. Approval Date
    2. Visit Date
    3. Export Date

- Select one of the parameters: 1) Approval Date
- Enter Starting Approval Date for the Report: Date
- Enter Ending Date for the Report: Date
- Select Output Device:

Example of Report for Billed HCPCS Procedures

BILLED MISCELLANEOUS (HCPCS) PROCEDURES Date Page 1

For (insurance) with APPROVAL DATES from xx to xx

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Code	Procedure Description	Count	Billed	Percent
A4206	1 CC Sterile Syringe & Needle	1	6.86	0.0%
A4245	Alcohol wipes per box	2	14.70	0.0%
A4253	Blood glucose/reagent strip	3	109.80	2.0%
A4259	Lancets per box	2	26.46	0.0%
A4454	Tape all types all sizes	16	28.80	0.0%
A4460	Elastic compression bandage	10	18.10	0.0%
A4565	Slings	1	7.14	0.0%
A4572	Rib Belt	3	24.12	0.9%

Billed Services And Collections

The following report, by either visit or clinic, will list the number of visits or number of patients per clinic along with the total dollars billed, reimbursed, and unpaid. This report will also total each of the columns.

- In the AR Master menu option, select Bill
- Select RPTP – Reports Menu
- Select STRP – Statistical Billed-Payment Report
- Select #2 – Billing Entity
- Select one of the following:
  1) Medicare
  2) Medicaid
  3) Private Insurance
  For this example, select #3 – Private Insurance
- Select #3 – Date Range
- Select one of the following:
  1) Approval Date
  2) Visit Date
  3) Payment Date
  For this example, select #1 – Approval Date
- Select one of the following:
  1. Location
  2. Billing Entity
  3. Date Range
  4. Approving Official
  5. Provider
  6. Eligibility Status
  7. Diagnosis Range
  8. CPT Range

Select the following parameter: 3) Date Range

- Enter Starting Approval Date for the Report, i.e., 0101
- Enter Ending Date for the Report – i.e., 0131
- Select one of the following:
  1) Location
  2) Billing Entity
  3) Date Range
  4) Approving Official
  5) Provider
  6) Eligibility Status
  7) Diagnosis Range
  8) CPT Range
- Select sorting of report by either Visit Type (V) or Clinic (C)
- Select Output Device

Example of Revenues Collected Report

STATISTICAL REPORT FOR (insurance) with VISIT DATES Date Page 1

From Dates of xx to xx

VISIT TYPE	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	UNPAID AMOUNT
Inpatient	69	59	39,062.00	37,856.00	1,206.00
Outpatient	1,616	671	277,952.00	241,039.59	39,912.41

Accounts Receivable (AR) Outstanding Report

This report will provide a listing of accounts by patient, by date of service, that are billed and unpaid.

- Go to the Accounts Receivable System Report Menu
- Select AGE – Age Report
- Select one of the following:
  - F – Facility
  - I – Insurer
  - C – Clinic
  - P – Patient
    - For this example, select I – Insurer
- Select Beginning Date, example T-60
- Select Ending Date, example T – 45
- Select one of the following:
  - I – Insurer
  - C – Clinic
  - B – BEN/NONBEN
    - For this example, enter I – Insurer
- Select Output Device

Age Summary Report

This report will provide a summary aging report by insurer based on date billed. The report will be divided into current, 31-60, 61-90, 91-120 and over 120 days. Totals will be reflected for each insurer.

- Go to the Accounts Receivable System Report Menu
- Select ASM - Age Summary Report
- Select one of the following:
  - F - Facility
  - I – Insurer
  - C – Clinic
  - P - Patient
    - For this example, select I – Insurer
- Select AOI – Age Open Items Report
- Select one of the following:
  1. 0-30
  2. 31-60
  3. 61-90
  4. 91-120
  5. 120+
- Select Output Device

Zero Dependent Entry Counts

To obtain data for this report, using the following directions:

- Select Visit Review Report Option: Visits with Zero Dependent Entry Count
- Select one of the following:
  1) Posting Date
  2) Visit Date
- Run Report by: P// osting Date
- Enter beginning Posting Date for Search: t-xx
- Enter Ending Posting Date for search: Date
- Select:
  -A All Locations/facilities
  -S One SERVICE UNIT'S locations/facilities
  -O ONE location/facility
- Enter a code indicating what LOCATIONS/FACILITIES are of interest: O//NE Location/Facility
- Which Location
- Select one of the following
  1) ALL visits in date range specified
  2) Only those visits flagged to be transmitted to DPSB
- Review which set of visits: 2// Only those visits flagged to be transmitted to DPSB
- This report will be sorted by Patient Health Record Number
- Selection one of the following:
  -T Terminal Digital Order
  -H Health Record Number Order
- Sort the report by: t// erminal Digit Order

Zero Dependent Entry Counts Report Example

Date Page 1

PCC Data Entry Module

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VISIT REVIEW ERROR REPORT

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Report of Errors for Posting Date Range: From Date – To Date

Location of Encounter:

Diabetes Mellitus -- Visits in the last 30 days without foot checks (QMAN Report)

To obtain data, use the following directions:

- What is the subject of your search? LIVING PATIENTS// LIVING PATIENTS
- Subject of search: PATIENTS
  ALIVE TODAY
- Attribute of LIVING PATIENTS: visit
- SUBQUERY: Analysis of multiple VISITS
- First condition of "VISIT: BETWEEN, DATES (inclusive)
- Exact starting date: DATE
- Exact ending date: DATE
- Next condition of "VISIT: POV
- Enter DX: 250.00-250.93
  DM UNCOOMPL/T-II/NIDDM,NS UNCON
- OK? YES// (Yes)
  250.93 DM W COMPL NOS/T, NS UNCON COMPLICATION/COMORBIDITY

Codes in this range=

250.0	DM UNCOMPL/T-II/NIDDN,NS UNCON
250.01	DM UNCOMPL/T-I/IDDM,NS UNCONT
250.02	DM UNCOMPL/T-II/NIDDM,CONTR
250.03	DM UNCOMP T-I/IDDM, UNCONTR
250.10	DM KETOACI/T-II/NIDDM,NS UNCON
250.11	DM KETOACID/T-I/IDDM,NS UNCONT
250.12	DM KETOACID/T-II/NIDDM,UNCONTR
250.13	DM KETOACID/T-I/IDDM, UNCONTR
250.20	DM HYPEROSMO/T-II/NIDDM,NS UNC
250.21	DM HYPEROSMOL/T-I/IDDM,NS UNC
250.22	DM HYPEROSMOLAR/T-II/NIDDM,UNC
250.23	DM HPERSMOLAR/T-I/IDDM,UNC
250.30	DM COMA NEC/T-II/NIDDM, NS UNC
250.31	DM COMA NEC/T-I/IDDM/NS UNCONT
250.32	DM COMA NEC/T-II/NIDDM,UNC
250.33	DM COMA NEC/T-I/IDDM,UNCONTR
250.40	DM RENAL/T-II/NIDDM,NS,UNCON
250.41	DM RENAL/T-I/IDDM,NS UNCONTR
250.42	DM RENAL MANIF/T-II/NIDDM, UNC

- Code Range(s) selected so far:
    1. 250.0 – 250.93
- Enter Another DX:
- Want to save this DX group for future use? No// (no)
  Subject of subquery: VISIT
  Between Date and Date
  POV (250.01/250.11)
- Next condition of "VISIT":
- Attribute of LIVING PATIENTS: diab
    1. Diabetic Exam
    2. Diabetic Eye Exam
    3. Diabetic Foot Check
    4. Diabetic Foot Exam, Complete
- Select 1-4: 3
- Select output device:

Example of Diabetic Foot Check Report

PATIENTS	VISIT	DIABETIC FOOT CHECK
(Alive)	NUMBER	EXAM

Patient Education for Diabetes Mellitus Patients (QMan report)

To obtain data, use the following directions:

- What is the subject of your search? LIVING PATIENTS// LIVING PATIENTS
- Subject of search: PATIENTS
  ALIVE TODAY
- Attribute of LIVING PATIENTS: visit
- SUBQUERY: Analysis of multiple VISITS
- First condition of "VISIT: BETWEEN, DATES (inclusive)
- Exact starting date: DATE
- Exact ending date: DATE
- Next condition of "VISIT: POV
- Enter DX: 250.00-250.93
  DM UNCOOMPL/T-II/NIDDM,NS UNCON
- OK? YES// (Yes)
  250.93 DM W COMPL NOS/T, NS UNCON COMPLICATION/COMORBIDITY

Codes in this range=

250.0	DM UNCOMPL/T-II/NIDDN,NS UNCON
250.04	DM UNCOMPL/T-I/IDDM,NS UNCONT
250.05	DM UNCOMPL/T-II/NIDDM,CONTR
250.06	DM UNCOMP T-I/IDDM, UNCONTR
250.14	DM KETOACI/T-II/NIDDM,NS UNCON
250.15	DM KETOACID/T-I/IDDM,NS UNCONT
250.16	DM KETOACID/T-II/NIDDM,UNCONTR
250.17	DM KETOACID/T-I/IDDM, UNCONTR
250.24	DM HYPEROSMO/T-II/NIDDM,NS UNC
250.25	DM HYPEROSMOL/T-I/IDDM,NS UNC
250.26	DM HYPEROSMOLAR/T-II/NIDDM,UNC
250.27	DM HPERSMOLAR/T-I/IDDM,UNC
250.34	DM COMA NEC/T-II/NIDDM, NS UNC
250.35	DM COMA NEC/T-I/IDDM/NS UNCONT
250.36	DM COMA NEC/T-II/NIDDM,UNC
250.37	DM COMA NEC/T-I/IDDM,UNCONTR
250.43	DM RENAL/T-II/NIDDM,NS,UNCON
250.44	DM RENAL/T-I/IDDM,NS UNCONTR
250.45	DM RENAL MANIF/T-II/NIDDM, UNC

- Code Range(s) selected so far:
  2. 250.0 – 250.93

- Enter Another DX:
- Want to save this DX group for future use? No// (no)
  Subject of subquery: VISIT
  Between Date and Date
  POV (250.01/250.11)
- Next condition of "VISIT":
- Attribute of Living Patients: Patient ED Tropic
  Between dates
  Exact starting date:
  Exact ending date:

Subject of search: Patients Alive Today
Select print or display

Example of report

Patients (Alive)	Visit Number	Patient ED Topic	Pt ED Date
Smith, John	11111	DM – Information	Nov 14, 2000